

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07919

7920

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 10 Yrs	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS 19 Charles Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fred	Middle Brown	4. DATE OF DEATH July 18, 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1903
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 18	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 265-12-4628	
17. INFORMANT Ruth Becton, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.2		INTERVAL BETWEEN ONSET AND DEATH 26 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension - Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/17 , 19 58 , to 7/18 , 19 58 that I last saw the deceased alive on 7/18 , 19 58 , and that death occurred at 1030 AM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. H. Hanics</i>		ADDRESS (Street, city or town, state) 104 Locust Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Waugh Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert Maxwell Jr.</i>		24a. REC'D BY REGISTRAR Aug 11 '58	24b. REGISTRAR'S SIGNATURE <i>John F. Smith</i>
ADDRESS Cambridge, Md.		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7921

CERTIFICATE OF DEATH

Reg. Dist. No.

117920

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galestown		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge General Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Nettie	Middle Pearl	Last Cannon	4. DATE OF DEATH July 8	Month July	Day 8	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Dorchester County, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Fisher				14. MOTHER'S MAIDEN NAME Elizabeth Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Maggie Wootten, Seaford, Del. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260 X				INTERVAL BETWEEN ONSET AND DEATH 2 mos			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DIABETES MELLITUS				UNKNOWN			
DUE TO (c) ARTERIOSCLEROSIS				UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 7/8 , 1958, to 7/8 , 1958, and that death occurred at 1:15 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 136 RACE ST					
ACTUAL SIGNATURE <i>Alfred R. Maryanov</i>	DATE SIGNED 7/10/58						
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV	CAMBRIDGE, MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-58	22c. NAME OF CEMETERY OR CREMATORIUM Galestown		22d. LOCATION (City, town, or county) Galestown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Spangler, Shagton, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JUL 14 '58		24b. REGISTRAR'S SIGNATURE <i>Que. Louch</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7930

CERTIFICATE OF DEATH

07921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First William	Middle Henry	Last Chester	
4. DATE OF DEATH	Month July	Day 24	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1875	
9. AGE (In years lost birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY Farming	12. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
13. FATHER'S NAME William Chester, Sr.	14. MOTHER'S MAIDEN NAME Nancy Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Oceola Chester, Cambridge, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH	
DUE TO 420.0				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cardiac Decompensation			1 yr	
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 7, 1957 , to July 24, 1958 , that I last saw the deceased alive on July 24, 1958 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St., Camb., Md.				
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	DATE SIGNED 7-26-58			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/27/1958	22c. NAME OF CEMETERY OR CREMATORIUM Beckwith Cemetery	22d. LOCATION (City, town, or county) RFD #3 Cambridge, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Clancy</i>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE AUG 11 '58	24b. REGISTRAR'S SIGNATURE <i>Robert W. Clancy</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7922

CERTIFICATE OF DEATH

07922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 60 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Church Street		d. STREET ADDRESS 109 Church Street								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard		First Elmer		Middle Dean		4. DATE OF DEATH July 1, 1958		Month July		Day 1		Year 1958	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 24, 1888		9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canning House Operator		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Taylors Island, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William H. Dean		14. MOTHER'S MAIDEN NAME Lovenia Dunnock											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Novella J. Dean, 109 Church St., Cambridge, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral haemorrhage, left, progressive		INTERVAL BETWEEN ONSET AND DEATH 7 days							
(b) Syphilitic CVD		DUE TO Diabetic Mellitus				Years Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b) Arterio-sclerotic Generalized								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County)		(State)			
21. I certify that I attended the deceased from alive on July 1, 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED July 3, 1958			
ACTUAL SIGNATURE J. H. Thompson		PHYSICIAN'S NAME (Type) James H. Thompson											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Levith R. Thompson		ADDRESS Cambridge, Md.		24e. REC'D BY REGISTRAR DATE JUL 7 '58		24b. REGISTRAR'S SIGNATURE Alt. Smith							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G232 7-30-58 et

07923

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>O. Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Secretary Ad life</i>		c. LENGTH OF STAY IN 1b <i>Ad life</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Secretary</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Louis Gary Gordon</i>		First <i>Louis</i>	Middle <i>Gary</i>			
4. DATE OF DEATH <i>7/19/58</i>		Month <i>July</i>	Day <i>19</i>			
5. SEX <i>Male</i>		6. COLOR OF HAIR <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>7-18-90</i>		9. AGE (In years last birthday) <i>68</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Boat</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>A. S. A.</i>		13. FATHER'S NAME <i>Joseph Gordon</i>				
14. MOTHER'S MAIDEN NAME <i>Errolle Blizzard</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>420-1</i>		17. INFORMANT <i>Lawrence Maryanov, Secretary M.D.</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>420.1</i> (b) DUE TO (c) Coronary Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>136 Race St.</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>7/19/58</i> , 19 <i>58</i> , to <i>7/19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7/19/58</i> , 19 <i>58</i> , and that death occurred at <i>10:00 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>136 Race St.</i>						
DATE SIGNED <i>Lawrence Maryanov M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/21/58</i>	22c. NAME OF CEMETERY OR Crematory <i>East New Market</i>	22d. LOCATION (City, town, & County) <i>Cambridge, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Thompson, East New Market, Md.</i>		23a. ADDRESS <i>136 Race St.</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 25 '58</i>			
			24b. REGISTRAR'S SIGNATURE <i>John W. Thompson</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07924

7932 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ceciliana Md</i>		c. LENGTH OF STAY IN 1b <i>Since 3-27-57</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>T. Tilghman Md - 20x-2</i>		d. STREET ADDRESS <i>so</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eastern Shore State Hosp-</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Sadie</i>		First	Middle	Last	HARRISON	4. DATE OF DEATH <i>7-5-1958</i>	Month Day Year	
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-23-1888</i>		9. AGE (In years last birthday) <i>70</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John T. Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Dela Francis Covington</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>422-1</i>		17. INFORMANT <i>Niece</i>		Address <i>Tilghman Rd</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Pneumonia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>13 1/2 day</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Chronic drys Carditis</i>		DUE TO (b) <i>Chronic drys Carditis</i>						
		DUE TO (c) <i>Ch. Brain Syndrome-Atero Sclerosis</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>493X</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Tilghman</i>		(County) <i>Talbot</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>3-28</i> , 19 <i>57</i> , to <i>7-5</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>7-5-1958</i> , and that death occurred on <i>7-5-1958</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edwin Ward</i>		M.D.				ADDRESS (Street, city or town, state) <i>Tilghman Tilghman Rd</i> DATE SIGNED <i>1958</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>July 7-58</i>		22b. DATE THEREOF <i>July 7-58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Tilghman Mtn.</i>		22d. LOCATION (City, town, or county) <i>Tilghman Tilghman Rd</i> (State) <i>Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin Ward Tilghman</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUL 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. - esuch</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07925

Reg. Dist. No.

PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge RFD #3		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cambridge RFD #3		d. STREET ADDRESS Cambridge RFD #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)													
3. NAME OF DECEASED (Type or print) Frank		First H. Middle		Last Hill		4. DATE OF DEATH 8/7		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/1880		9. AGE (In years last birthday) 117 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Neck Dist. Dorchester		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Hill		14. MOTHER'S MAIDEN NAME Amanda											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-0847		17. INFORMANT Audry H. Burns		Address 112 East Ave. Baltimore, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral hemorrhage										2 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)											
DUE TO													
DUE TO													
DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Ace Jr.</i>												DATE SIGNED 7/12/58	
EXAMINER'S NAME (Type) John Ace Jr.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/58		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge, Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR •DATE JUL 15 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. Le Compte</i>							

BY RONALD HEATH FOR THE NEW YORK TIMES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7934 CERTIFICATE OF DEATH

07926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Arthur	Middle Jerome	Last Hunter	4. DATE OF DEATH JULY 19 1958	Month July	Day 19	Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Joseph Hunter		14. MOTHER'S MAIDEN NAME Rebecca Embert						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1K0		17. INFORMANT Eastern Shore State Hospital records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH 420.1 UNK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <u>Mar 9</u> , 1953, to <u>July 19</u> , 1958, that I last saw the deceased alive on <u>July 18</u> , 1958, and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. DATE SIGNED								
PHYSICIAN'S NAME (Type) Thomas J. Dredge								
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-22-58		22b. DATE THEREOF 7-22-58		22c. NAME OF CEMETERY OR CREMATORIAL Medical School		22d. LOCATION (City, town, or county) Baltimore, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE 23 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Remove, and in any event within 72 hours after death,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7935 CERTIFICATE OF DEATH

07927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Dorchester MARYLAND		Md. Dor.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
Durlock	all life	Durlock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
William Edward Hurlock		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
William Edward Hurlock		First	Middle
Last		4. DATE OF DEATH	Month
Hurlock		7/14	Day
Year		1958	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost by birth)	10. IF UNDER 1 YEAR IF UNDER 24 HRS.
4/2/1886		72 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country)
Painter Red. of house, even decorated		Cow/Queen	Maryland, U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
J. B. Hurlock		Molly Parvin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No			Mrs. F. E. Durlock, Durlock Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 days.	
177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardiac Failure	
DUE TO (b)		Primary CARCINOM Prostate	
DUE TO (c)		With General Bone Metastasis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2/14/58	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14/58 to 7/14/58, 1958, that I last saw the deceased alive on 7/13/58, 1958, and that death occurred at 6:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		W. F. Lennon M.D. Federal St. Md. 7/15/58	
PHYSICIAN'S NAME (Type)		W. F. LENNON M.D. Federal St. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		7/16/1958	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Washington		Durlock, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
J. B. Hurlock, Federal St. New Mexico, Md.		DATE JUL 21 1958	
24b. REGISTRAR'S SIGNATURE		Aut. 1958	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7936

CERTIFICATE OF DEATH

07928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Perry		First Edward	Middle Johnson
4. DATE OF DEATH July 18 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1, 1887
9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmhand	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Talbot County, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Johnson		14. MOTHER'S MAIDEN NAME Sarah Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-5892	17. INFORMANT Edward Johnson, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Cerebral hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerosis			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cataract right eye			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-13-49 , 19, to 7-18-58 , 19, that I last saw the deceased alive on 7-16-58 , 19, and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 7-21-58			
ACTUAL SIGNATURE <i>Edward E. Bunker.</i>		M.D.	
PHYSICIAN'S NAME (Type) Albert E. Bunker, M. D.		Cambridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/21/1958	22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery
22d. LOCATION (City, town, or county) Cambridge, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wesley McElroy</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE AUG 11 '58
		24b. REGISTRAR'S SIGNATURE <i>Albert E. Bunker</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: A certificate must be executed within 24 hours for every fetal death of 20 weeks gestation or more. At 20 weeks, the fetus overages 10 inches in length, 9 ounces in weight, and the eyelids are opening. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR (or person acting as such): After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as a burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and, ~~any~~ event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item e FilmG238 1-29-59 et

14429

13144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DELIVERY

a. COUNTY

Dorchester

MARYLAND

b. CITY (If outside corporate limits, write RURAL and give township)
OR
TOWN

Cambridge

c. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Cambridge-Maryland Hospital

3. NAME OF FETUS (if given)

Sharon

Baby //

Denise

Lankford

4. SEX OF FETUS

Female

5a. THIS DELIVERY

SINGLE TWIN TRIPLET

5b. IF TWIN OR TRIPLET.

1ST 2ND 3RD

6. DATE OF DELIVERY

(Month) (Day) (Year)

July 17

19 58

FATHER

7. NAME

o. (First)

b. (Middle)

c. (Last)

8. COLOR OR RACE

Preston

Lankford

Negro

MOTHER

12. MAIDEN NAME

Clara

o. (First)

b. (Middle)

c. (Last)

13. COLOR OR RACE

Negro

17. INFORMANT

CAUSE OF FETAL DEATH

1. DIRECT AND ANTECEDENT CAUSES

IMMEDIATE CAUSE

State fetal or maternal condition directly causing fetal death

754.5

CAUSE OF FETAL DEATH

ANTECEDENT CAUSES

State fetal and/or maternal conditions, if any, giving rise to the above cause (o) stating the underlying cause last.

19a. FIRST DAY OF LAST NORMAL MENSES

19b. WEIGHT OF FETUS

(Month)

(Day)

(Year)

19

57

8

LB.

.00

OZ.

or

grms.

22a. I certify that this delivery occurred on the date stated above and the fetus was born dead.

(Enter only one cause per line)

Congenital Deformities
Due to
(a) Heart (three chambers)
(b) Transposition of organs
(c) Due to

11. OTHER SIGNIFICANT CONDITIONS of fetus or mother which may have contributed to fetal death, but, in so far as is known, were not related to direct cause of fetal death.

20. WHEN DID FETUS DIE
BEFORE LABOR DURING LABOR OR DELIVERY UNKNOWN
M. D. OTHER (Specify)
MIDWIFE 21. WAS AUTOPSY PERFORMED?
YES NO
22c. DATE SIGNED
8/3/5822b. ATTENDANT'S SIGNATURE
M. D. OTHER (Specify)
MIDWIFE
22d. ATTENDANT'S NAME
(Type or Print) W. H. Hanks 104 Locust Sr. Cambridge Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

7/17/1958

23c. NAME OF CEMETERY OR CREMATORIAL

Waugh Cemetery

23d. LOCATION (City, town, or county)

Cambridge, Md.

(State)

24. FUNERAL DIRECTOR

Herb W. Hanks

ADDRESS

Cambridge, Md.

25. REC'D BY REGISTRAR

AUG 11 '58

REGISTRAR'S SIGNATURE

A. H. Hanks

2017297X3

Dr. Banks verified that this child
was born alive but lived only a short time
1/29/59 - Mat.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
 the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7923

CERTIFICATE OF DEATH

07929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 249 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Richard		First	Middle	Lost	4. DATE OF DEATH July 31, 1958	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Nov. 4, 1890	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Night Watchman		11. BIRTHPLACE (State or foreign country) Vienna, R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Levin M. Lewis		14. MOTHER'S MAIDEN NAME Sarah Marshall		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-7255		17. INFORMANT Gladys Lewis, 404 Somerset Ave., Salisbury, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Central haemorrhage, cerebral Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO Arter - sclerotic CVD. (c) Arterio - sclerotic gen.			INTERVAL BETWEEN ONSET AND DEATH 15 hrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis agitans.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) July 31, 1958	(County)	(State)	
21. I certify that I attended the deceased from July 30, 1958 , to July 31, 1958 , that I last saw the deceased alive on July 31, 1958 , and that death occurred at 1:20 AM , from the causes and on the date stated above. ACTUAL SIGNATURE R. R. Shouest		M.D.		ADDRESS (Street, city or town, state) Cambridge, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Lewis Family Cemetery		22d. LOCATION (City, town, or county) Lewis Wharf, Vienna, R.F.D.			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shouest		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR Aug 4 '58		24b. REGISTRAR'S SIGNATURE Alfredrich			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7937 CERTIFICATE OF DEATH

07930
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 23yr. 1mo. 16da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showells,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 23x-2	
3. NAME OF DECEASED (Type or print)	First Ella	Middle M.	Last Massey
4. DATE OF DEATH	Month July	Day 1	Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-77
9. AGE (In years lost birthday) 81	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Pointer	14. MOTHER'S MAIDEN NAME Jennie Lewis	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unkn.	
16. SOCIAL SECURITY NO. -	17. INFORMANT RECORDS - Eastern Shore State Hospital	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Pyelitis - Sub-acute DUE TO (c) Arteriosclerosis, Generalized			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 11, 1956 , to July 1, 1958 , that I last saw the deceased alive on July 1, 1958 , and that death occurred at 2:36aM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 7-1-58			
ACTUAL SIGNATURE <i>Edwin J. Ward</i>	M.D.		
PHYSICIAN'S NAME (Type) Dr. Edwin J. Ward			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/3/58	22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN	22d. LOCATION (City, town, or county) BERLINV (State) M.D.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna M. Bubba</i>	ADDRESS 1000 E. Berlin Rd., Berlin, Md.	24a. REC'D BY REGISTRAR DATE JUL 7 '58	24b. REGISTRAR'S SIGNATURE Rebekah

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE TB

CERTIFICATE OF DEATH

5004

MAY 1962

MURKIN

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
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1 X
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7924 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07931

Reg. Dist. No.

Items 8 & 9, Film G-233 8/27/58.cac.			
1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 218 West End Avenue		d. STREET ADDRESS 1 218 West End Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lena Robbins Meekins		4. DATE OF DEATH Month 7 Doy 17 Year 19 58	
5. SEX female white		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 4/19/1889 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 4/18/1887 9. AGE (In years from birthday) 69 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Robbins		14. MOTHER'S MAIDEN NAME Mary Jane Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Frank G. Meekins, 218 West End Ave., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ceberal Hemorhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH About 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED 2/20/58	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John Mace Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/20/58	
22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Pk		22d. LOCATION (City, town, or county) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alt. Leach</i>	
VS. A15ME SM 2/57			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7938

CERTIFICATE OF DEATH

07932

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY		DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY		TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CAMBRIDGE		c. LENGTH OF STAY IN 1b		17 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First MIDDLE LAST		4. DATE OF DEATH		JULY 27 1958		Month Day Year			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
FARMER				MARYLAND		U.S.A.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
EDWIN W. MILLER		MATTIE THOMPSON									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
		XXXX		EASTERN SHORE STATE HOSPITAL RECORDS							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ARTERIOSCLEROTIC HEART DISEASE								SEVERAL YEARS	
420.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u>		(b)								SEVERAL YEARS	
DUE TO		(c)		GENERALIZED ARTERIOSCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that I attended the deceased from		2-28 1958		to		7-27 1958		that I last saw the deceased			
alive on		7-27 1958		and that death occurred at		6:15 AM		from the causes and on the date stated above.			
ACTUAL SIGNATURE		George E. Currier		M.D.		EASTERN SHORE STATE HOSPITAL		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type)		GEORGE E. CURRIER				CAMBRIDGE, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		July 30, 1958		Deezer Cemetery		Rowley		W. Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Maurice E. Currier & Son				DATE AUG 1 '58		W. Currier					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7939

CERTIFICATE OF DEATH

07933

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 4 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2212-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 808 ALVIN Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sarah Pauline Purnell		First	Middle	Last	4. DATE OF DEATH JULY 16 1958	Month	Day	Year	
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4-16-97	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Henrietta White							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1		17. INFORMANT Eastern Shore State Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Shad Point	(County)	(State)	
21. I certify that I attended the deceased from April 8, 1958, to July 16, 1958, that I last saw the deceased alive on July 16, 1958, and that death occurred at 3:55 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 4-16-58 PHYSICIAN'S NAME (Type) Thomas J. Dredge E.S.S. Hospital, Cambridge, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/18/58	22c. NAME OF CEMETERY OR CREMATORIAL White Cemetery	22d. LOCATION (City, town, or county) Shad Point, Maryland		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson SALISBURY, MD Norman & Bales		ADDRESS Hill & Johnson SALISBURY, MD	24a. REC'D BY REGISTRAR JUL 18 '58	24b. REGISTRAR'S SIGNATURE DeLoach					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as a Burial-Transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

MARRIED

at 11:00

Housewife Constance Marylina

20, 1961, at 11:00

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Life		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS 177 Washington Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Viola		First Jarmon	Middle Ross
4. DATE OF DEATH July 1 1958		Lost	Month Day Year
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 6, 1921 9. AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rickson Jarmon		14. MOTHER'S MAIDEN NAME Viola Henry Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 216-16-7443 17. INFORMANT George Ross, Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)		Myocarditis INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) ALFRED R. MARYANOV		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Old Field Cemetery		22d. LOCATION (City, town, or county) Dorchester Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Clark Jr.		ADDRESS Cambridge, Md.	
		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Jul 8 '58	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

17935

7926

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 24 High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Leroy		First	Middle	Last	4. DATE OF DEATH July 6, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1886	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocer self employed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge, R.D.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James S. Smith		14. MOTHER'S MAIDEN NAME Nancy Henry						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Hazel M. Smith, 24 High St., Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Cerebral hemorrhage, right				INTERVAL BETWEEN ONSET AND DEATH 3 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		arteriosclerosis, generalized and cerebral				10 years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. --		20d. INJURY OCCURRED While Not while at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --		20f. (City or town) -- -- --		(County) (State)
21. I certify that I attended the deceased from 6-28-1958, to 7-6-1958, that I last saw the deceased alive on 7-6-1958, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Eldridge H. Wolff PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.								ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Katherine R. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 11 '58		24b. REGISTRAR'S SIGNATURE Albert E. Cook		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7927

CERTIFICATE OF DEATH

07936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hurlock - Rural		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS / Railroad Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Evelyn		Middle		4. DATE OF DEATH July 3 1958		Month Day Year	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 2, 1945	
9. AGE (In years lost birthday) 12 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		11. BIRTHPLACE (State or foreign country) East New Market, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles M. S. Stanley		14. MOTHER'S MAIDEN NAME Cecelia Thompson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Cecelia Stanley, Hurlock, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 093X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Encephalitis, acute Infection mononucleosis				INTERVAL BETWEEN ONSET AND DEATH 7 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatitis seen to (b)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28</u> , 1958, to <u>July 3</u> , 1958, that I last saw the deceased alive on <u>July 3</u> , 1958, and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above. ACTUAL SIGNATURE M.D. Cecelia Thompson						ADDRESS (Street, city or town, state) Cambridge	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1958		22c. NAME OF CEMETERY OR CREMATORIUM East New Market Cemetery		22d. LOCATION (City, town, or county) (State) East New Market, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 16 '58		24b. REGISTRAR'S SIGNATURE A. L. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7940

CERTIFICATE OF DEATH

Reg. Dist. No.

07937

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1yr. 6mo. 11days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Harrison	Middle Wilson	Last Vickers, Jr.	4. DATE OF DEATH July 30 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> separated <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-79	9. AGE (In years from birth) 79 yrs.
				10. IF UNDER 1 YEAR Months 0 Days 0
				11. IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	---	--	---

13. FATHER'S NAME Harrison Vickers	14. MOTHER'S MAIDEN NAME Jennie ? B. Y. Shemwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. NO 217-16-9450	17. INFORMANT RECORDS-Eastern Shore State Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis	
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) General Arteriosclerosis	
DUE TO (c) —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. 19 p. m. —	Month, Day, Year —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) —	(County) —	(State) —	

21. I certify that I attended the deceased from **June 19 57** to **July 30 1958**, that I last saw the deceased alive on **July 30 1958**, and that death occurred at **4:50 P.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE *Ettore De Filippis* M.D. **E.S.S. Hospital, Cambridge, Md.** 7-31-58

PHYSICIAN'S
NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Chestertown	22d. LOCATION (City, town, or county) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE MARVIN Williams	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE AUG 1 '58	24b. REGISTRAR'S SIGNATURE Out. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07938

CERTIFICATE OF DEATH

Reg. Dist. No.

2928

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 13		d. STREET ADDRESS 407 Glenburn Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Holly	Middle Virginia	Last Walker	4. DATE OF DEATH July	Month 23	Day 19	Year 58
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-58	9. AGE (In years last birthday) 0 yrs.	10. IP UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 2	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Cambridge, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Reginald W. Walker			14. MOTHER'S MAIDEN NAME Hazel Virginia Hackett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Reginald W. Walker, Cambridge, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u> DUE TO 773.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity - Birth Weight 4 lbs. 7 ozs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Hour a. m. p. m.	Month ---	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---
21. I certify that I attended the deceased from <u>July 21, 1958</u> , to <u>July 23, 1958</u> , that I last saw the deceased alive on <u>July 23, 1958</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D. <u>15 Locust Street</u> DATE SIGNED <u>7-23-58</u>							
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M. D.</u> Cambridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Memorial Park	22d. LOCATION (City, town, or county) Cambridge, Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leuneth R. Shover</u>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE <u>JUL 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Carl E. Smith</u>				

CERTIFICATE OF DEATH

OIC-10250

RECEIVED

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DEPARTMENT OF HEALTH

DIVISION OF DEATH

DEATH CERTIFICATES

REGISTRATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7929

Item 8 Film G231 7-22-58 st

CERTIFICATE OF DEATH

Reg. Dist. No. 07939

1. PLACE OF DEATH a. COUNTY	Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	Maryland Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cambridge MD			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cambridge 13		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	301 Clinton St.			d. STREET ADDRESS	301 Clinton St.		
3. NAME OF DECEASED (Type or print)	First DANIA	Middle L	Last Weatherly	4. DATE OF DEATH	Month 7	Day 9	Year 1958
5. SEX m	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 30, 1896	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY PAINTER	11. BIRTHPLACE (State or foreign country) Contractor Baltimore City	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME TRAIN Bichum Weatherly	14. MOTHER'S MAIDEN NAME MARY Young						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 217-10-81190	17. INFORMANT Carrie Cornish Cambridge	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Causes of death Congestive Heart failure Stroke & Malnutrition Ca. of lung & metastasis to bone	INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from May 1958 to July 1958, that I last saw the deceased alive on July 1958, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type)	M.D.	ADDRESS (Street, city or town, state) Cambridge, Md.	DATE SIGNED July 27, 1958				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-13-1958	22c. NAME OF CEMETERY OR CREMATORIAL Airey's	22d. LOCATION (City, town, or county) (State) Dorchester Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Leon W. Henry Cambridge Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JULY 16 1958	24b. REGISTRAR'S SIGNATURE John J. Smith				

DEPARTMENT OF HIGHWAY-BAKERSFIELD
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7941

CERTIFICATE OF DEATH

07940

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 4 YRS. 2 MOS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLARDS		d. STREET ADDRESS 22 x - 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FORD		First	Middle	Last	4. DATE OF DEATH WILKINS	Month JULY	Day 13	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12 1885	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 13	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY STEAM MILL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME LAURA WILKINS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Arthur Bradford (Son-In-Law)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) LOBAR PNEUMONIA DUE TO (c) CEREBRAL THROMBOSIS CEREBRAL ARTERIC SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 490X CHRONIC BRAIN SYNDROME								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from APR 25, 1957 , to JULY 13, 1958 , that I last saw the deceased alive on JULY 13, 1958 , and that death occurred at 11:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CAMBRIDGE, MARYLAND DATE SIGNED July 13, 1958								
ACTUAL SIGNATURE Harry J. Crawford		M.D.						
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Willards Cemetery		22d. LOCATION (City, town, or county) Willards, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE JUL 18 '58		24b. REGISTRAR'S SIGNATURE Reese		

